

## PSYCHOLOGICAL DIVIDENDS OF SOCIAL SKILL TRAINING (SSTT) AND GROUP THERAPY TECHNIQUES (GTT) IN THE MANAGEMENT OF PSYCHOPATHOLOGY ASSOCIATED WITH SCHIZOPHRENIA IN THE SOUTH / WEST NIGERIA

Ajibade, B.L<sup>1</sup>, Ejidokun Adeolu, <sup>2</sup>Olaoye, Kayode<sup>3</sup>, Fabiyi B.O<sup>4</sup> Ajao O O.<sup>5</sup>, Olabisi, O.I<sup>6</sup>

1. Ladoke Akintola University of Technology, Ogbomoso, College of Health Sciences, Faculty of Clinical Sciences, Department of Nursing Sciences, Osogbo Osun State
2. Neuropsychiatric Hospital, Yaba, Lagos State Nigeria
3. Neuropsychiatric Hospital, Aro, Abeokuta, Ogun State, Nigeria
4. Lautech Teaching Hospital, Ogbomoso, Oyo State, Nigeria
5. State School of Nursing, Ado Ekiti. Ekiti State, Nigeria.
6. Baptist Medical Centre School of Nursing, Shaki

Correspondence to :Dr Ajibade, Bayo Lawal, Ladoke Akintola University of Technology Ogbomoso, College of Health Sciences, Faculty of Clinical Sciences, Department of Nursing Science, Osogbo Osun State, Nigeria  
Zip code 11200

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**ABSTRACT:** *Introduction: No Psychological disorder is more crippling than schizophrenia. Characteristically, disturbances of thought processes, perception, and affect invariability result in a severe deterioration of social and occupational functioning. Therefore, this research was carried out to assess the efficacy of psychological management in the reduction of psychopathology associated with schizophrenia Methodology: The research adopted the between subject 4 x 4 factorial design, using four hundred and twenty five (425) patients. The settings were selected purposively while the subjects are assigned to SSTT only, 'GTT' only, combination of 'SSTT and GTT', and control. The treatment lasted for eight (8) weeks three (3) null hypotheses were tested at 0.05 level of significance. Results: The results showed that only combination of SSTT and GTT had impacts on the reduction of psychopathology associated with schizophrenia. The result also showed that chronic patients with schizophrenia improved better than acute patients'. Conclusion: It was concluded that not a single psychological management method can reduce the psychopathology associated with schizophrenia. Therefore, eclectic approach should be involved in the management of patients with schizophrenia.*

**KEYWORDS:** Psychological dividends, Social Skill (SSTT) Group Therapy (GTT), Psychopathology, Acute Schizophrenia, Chronic Schizophrenia

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## INTRODUCTION

### Background

Perhaps no psychological disorder is more crippling than schizophrenia. Characteristically, disturbances in thought processes, perception, and affect invariability result in a severe deterioration of social and occupation functioning (Townsend, 2002 cited Hollingsworth, 1990). Over the years, much debates have surrounded the concept of schizophrenia. Various

definitions of the disorder have evolved, and numerous treatment strategies have been proposed, but none have proven to be uniformly effective or sufficient. Although the controversies lingers, two general factors appear to be gaining acceptance among clinicians. The first is that schizophrenia is probably not a homogenous disease entity with a single cause, but rather it likely result from a variable combination of genetic predisposition, biochemical dysfunction, physiological factors and psychosocial stress. The second factor is that there is not now and probably never will be a single treatment that cure the disorder instead, effective treatment requires a comprehensive, multidisciplinary efforts, including pharmacotherapy and various forms of psychosocial care such as living skills and social training, rehabilitation and family therapy (Townsend, 2002). She went further to say that of all mental illnesses responsible for suffering in society, schizophrenia probably causes more lengthy hospitalizations, more chaos in family life, more exorbitant costs to individuals and governments, and more fears than any other. The effectiveness of antipsychotic medication has made it central to the treatment of schizophrenia (Pilling, et al 2002).

However, there is an increasing acknowledgement that pharmacological treatment on its own is rarely sufficient for the best outcome in this disabling condition. There are a number of reasons for this. First, the issue of compliance has made it clear that the social and cognitive context in which pharmacological treatment is delivered has major effect on its success (Bebbington & Kuipers, 1994). Secondly, the effectiveness of antipsychotic medication has to some extent been called into question. This came about because of the interest in treatment resistance fostered by the introduction of clozapine. Thus, it is now generally held that a significant proportion of patients, perhaps up to 40%, have a poor response to antipsychotic medication and continue to show moderate to severe psychotic symptoms (Kane, 1996).

## **LITERATURE REVIEW AND THEORETICAL FRAME WORK**

**Overview of social skill training techniques and group therapy.** Social skills training refers to a class of interventions, based on social learning theories, that aim to teach the perceptual, motor and interpersonal skills deemed relevant to achieving community survival, independence and socially rewarding relationship. Complex behaviours are assessed and broken down into smaller discrete components taught through various behavioural techniques such as problem specification, instruction, modeling, role playing, behavioural rehearsal, coaching, reinforcement, stretched feedback and home – work assignment. The focus of social skills training programmes has recently move from topographical features of overt behavior to a more comprehensive range of communication and independent living skill (Halford & Hayeb, 1992). There is little doubt that people with schizophrenia can learn a variety of social skills, ranging from simple motor behaviours to more complex ones such as assertiveness and conversational skills (Penn & Mueser, 1996). Kannappan (2009), concluded that family intervention might be an important means of increasing the effectiveness of treatment for schizophrenic patients and of helping relatives and clinical in the task of better dealing with the illness and it consequences. The patients attitude toward the medication is likely to offer important benefits in terms of compliance patients satisfaction and clinical effectiveness through the use of family therapy (Kannappa, 2009; Mniller, Dworken, Ward & Barone, 1990; Solomon & Drane, 1995; Thorneycroft et al, 2004; Kreisma, & Joy, 1974; Hatfied & Lefley, 1987; Franks, 1987, Stanley & Shwetha, 2006). Kannappan (2009), concluded that the symptoms of the schizophrenia were reduced remarkable using focused group intervention. Intervention was beneficial increased coping

ability of communication, decision making problem solving and drug compliance. According to Townsend (2002) social skills / training has become one of the most widely used psychosocial intervention in the treatment of schizophrenia. The educational procedure in social skills training focuses on role play. A series of brief scenarios are selected. These should be typical of situations clients' experiences in their daily lives, and they should be graduated in terms of level of difficulty (Bellack, 1984). A number of studies on the efficacy of group therapy in the treatment of schizophrenia have reported meager but positive results, particularly with out patients and when combined with drug treatment (Cutting, 1985, Kaplan & Sadock, 1988). Kaplan and Sadock (1985), states

“Results are more likely to be positive when treatment focused on real – life plans, problems and relationship, on social and work roles interaction, on cooperation with drug therapy and discussion of the side effect, or an some practical recreational or work activity (p 224)

### **Group therapy**

Group therapy in inpatient settings is less productive. In patient treatment usually occurs when symptomatology and social disorganization are at their most intense. At this time, the least amount of stimuli possible is most beneficial for the client. Because group therapy is, infact, a multistimulus situation frequently high in intensity, it maybe counterproductive early in treatment (Keith & Matthews, 1984). According to Kaplan and Sadock (1998), group therapy for schizophrenia has been most useful over the long – term course of the illness. The social interaction, sense of cohesiveness, identification, and reality testing achieved within the group setting have proven to be highly therapeutic processes for these clients. Groups led in a supportive manner, rather than in an interpretative way, appear to be most helpful for schizophrenic clients. Focused therapy has similarities with motivational interviewing and the two interventions have been successfully used in medical settings and with families. A marriage or combination of the two is proposed as essential to the practice of medical family therapy, the field of nursing has demonstrated success using intervention drawn from focused therapy and motivational interviewing in patients care Holford & Hayes (1992).

The effectiveness of psychotherapy and psychosocial treatment in the treatment of psychological disorder has gained popularity more than decades. It has been discovered that the negative symptoms of schizophrenia with motivation, social interactions, affective experience and responsiveness, clarity of speech and slowed movement contributed to poor functional outcome and quality of life. But these above listed symptoms are more responded to psychotherapies which modify in terms of improved functional outcomes, including independent of living skills, social functioning and role function. Comparing group therapy with individuals therapy in the treatment of schizophrenia, studies have supported the value of group therapy for schizophrenia patient. In group analytic therapy with schizophrenic out patients, some authors have divergent believe contrary to previous findings, that group analytic therapy is an effective method to treat schizophrenia outpatients but the therapist must take more active approach at the beginning (Chazzan, 1992). The group analytic psychotherapy is in advantage from individuals therapy in relation to transference and reality testing, the reason why group therapy work so well for schizophrenia patients were emphasized by chains that the first task of a group is to learn to communicate, which has two components, finding a common language and learning to take part in group dialogue, this is important because neologisms leads to confusion among the group, but to foster understanding the individual member has to learn to be part of the group neither to receded

into background nor to dominate, to listen as well as to speak, secondly group members need to behave toward the group as they behave toward significant other in life, this is particularly important for schizophrenics to develop new forms of relating (Chazzan, 1999). Functional adaptation skill training psychosocial intervention (24 group sessions) designed to improve everyday living skills of middle aged and older patients with very chronic psychotic disorders (Paterson 2003). Integrating schizophrenic clients is used to provide optimal adjustment to the disease (Urlick, 1998). Psycho – educational multiple family group treatment among patient with schizophrenia resulted in a lower rate of psychiatric hospitalization comparing group therapy with individual therapy in the treatment of schizophrenia, sties have supported the value of group for schizophrenia patient (Dyek, 2002). A substantial literature on family interventions for people with schizophrenia has emerged over the last 20 years. Recent reviews have generally accepted the efficacy of these interventions, especially in preventing patient relapse, but have raised questions over their potential effectiveness in routine care (Hesley et al, 2000; Ballack 1984). Husely et al(2000) reviewed 25 studies spanning a 200 year period. They concluded that no evidence was available showing clear differences in outcomes between different models of interventions. Huxley, Rendal, and Sederere (2000), in a review of 18 family interventions, cited three studies that had compared theoretical orientations: multiple – family behavior therapy us, multiple – family psycho – education , dynamic vs behavioural; and behavioral vs supportive. The differences between thee orientations were e’small’ (Huxley et al, 2000, p 193), with none demonstrating overwhelming superiority over their comparison intervention.

**Concept of schizophrenias:** According to Olatawura (2002), schizophrenias refer to a group of mental disorders in which many clinical pictures can occur. The went further to say that the diagnosis of schizophrenia depends on the presence of delusions and halluanations which result in abnormal behavior, including abnormal talk by the patient. Because some of these futures are also seen in acute and transient psychotic disorders in order to make a diagnosis of schizophrenia, these symptoms must be shown to be present for at least a month. Olatawura (2002) cited Bleuler (1915) stated that schizophrenia was first used by Bleuler (1911) because according to him, the function of the mind, namely thinking, feeling, rezoning etc do not work together harmoniously as it is aim normal people. He went further to say that according to Bluder, those functions appear split from one another. A schism exists. He reasoned that schizophrenias was a better term than that suggested by E. Kremlin who gave the disease the label of dementiapræcox’. According to kraepelin, the condition always occurred in adolescence (Pre – consciously) and led to intellectual impaivement. To him, the disease is presented as premature dementia, since dementia is a disease of old age. All these points, according to Olatawura (2002) are put together in the international classification of disease (ICD-10) a follows.

“The schizophrenic disorder are characterized in general by fundamental and characteristic distortion of thinking and perception, and by inappropriate and blunted affect clear consciousness and intellectual capacity are usually maintained although certain cognitive deficits may evolve in corves of time. The most intimate thoughts, feeling’s and acts are often felt to be known to or shared by others, and explanatory delusions may develop to the effect that natural or supernatural forces are at work to influence the individual’s thoughts and actions in ways that are often figure ... hallucinations, especially auditory, are common and may comment on the individuals behavior or thoughts” ... (Pp129)

**Nature of schizophrenia:** Perhaps no psychological disorder is more crippling than schizophrenia. Characteristically, disturbances in thought processes, perception, and affect invariably result in a severe deterioration of social and occupational function (Holland & Worth, 1990). Approximately 1 percent of the population will develop schizophrenia over the course of a life time (Birchwood et al. 1989) societal economic costs are estimated in billions of dollars per yr. symptoms generally appear in Late adolescence or early adulthood, although they may occur in middle or late adulthood (American Psychiatry Association (APA, 2000.) Some student have indicate that symptoms occur earlier in men than women. The premorbid personality usually indicates social and sexual maladjustment or schizoid, paranoid or borderline personality characteristics (Cutting, 1985, Ptohl & Winokur, 1985). This premorbid behavior is often a predictor in the paltorn of development of schizophrenia which can be viewed in four (4) phases.

❖ **Phase 1:** The schizoid personality. The DSM – IV – TR (APA, 2000) describes the individual with schizoid permality as being indifferent to social relationship and being a very limited range o emotional experiences and expression. They do not enjoy close relationship and prefer to be ‘loners’. They appear cold and aloof not all individuals who demonstrate the characteristics of schizoid personality will progress to schizophrenia. However, most individual with schizophrenia show evidence of having had these characteristics in the pre – morbid condition

❖ **Phase II:** the prodromal phase. According to Townsend (2002), the characteristics of the prodromal. Phase include social withdrawal; impairment in role functioning; behavior that is peculiar or eccentric, neglect or personal hygiene and grooming; blunted or inappropriate affect; disturbances in communication; bizarre ideas; unusual perceptual experiences, and lack of initiative, interests, or energy. The length of this phase is highly variable and may last for many years before determination to the schizophrenic state.

❖ **Phase III:** Schizophrenia in the active phase of the disorder, psychotic symptoms are prominent following are the DSM – IV – TR (APA, 2000) diagnostic criteria fro schizophrenia:

1. Characteristic symptoms – two (or more) of the following, each present for a significant potion of time during a 1 – month period ( or less if successfully treated).

- (a) Delusions
- (b) Halluantions
- (c) Disorganized speech (e.g frequent derailment, incoherence)
- (d) Grossly disorganized or cationic behavior
- (e) Negative symptoms (i.e affective flattening, logia or abolition

2. **Social / occupational dysfunction :** for a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self – care are markedly below the level achieved prior to the on-set (or when the onset is in childhood or adolescence, failure to achieve prior to the on-set (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement

3. **Duration:** Continuous signs of the disturbance persist for at least 6 months. This 6 months period must include at last criterion I (i.e active phase symptoms) and may included periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in criterion 1 present in an attenuated form (e.g odd beliefs unusual perceptual experiences).

4. **Schizoaffective and mood disorder Exclusion:** Schizoaffective disorder and mood disorder with psychotic feature have been ruled out because either (i) no major depressive, manic or mixed episodes have occurred concurrently with the active – phase symptoms or (2) if mood episodes have occurred during, active – phase symptoms, their total duration has been brief relative to the duration of the active and residual periods

5. **Substance / general medical condition exclusion:** The disturbance is not a result of the direct physiological effects of a substance e.g a drug of abuse, a medication or a general medication condition

6. **Relationship to a pervasive developmental disorder.** If there is a history of autistic disorder or another pervasive developmental disorder, the additional diagnosis of schizophrenia is made only if prominent delusion or hallucination also are present for at least a month (or less of successfully treated).

❖ **Phase IV. Residual Phase:** Schizophrenia is characterized by periods of remission and exacerbation. A residual phase usually follows an active phase of the illness symptoms during the residual phase are similar to those of the prodromal phase, with flat affect and impairment in role functioning being prominent. Residual impairment often increases between episodes of active psychosis. A return to full premorbid functioning is not common (APA, 2000). However, several factors have been associated with a more positive prognosis. They include good pre – morbid adjustment, later age of onset, being female abrupt onset of symptoms precipitated by a stressful event (as opposed to gradual insidious onset of symptoms) associated mood disturbance, brief duration of active phase symptoms good inter episode functioning, minimal residual symptoms, absence of structural brain abnormalities, normal neurological functioning a family history of mood disorder, and no family history of schizophrenia (APA,2000)

**Etiological implications:** the cause of schizophrenia is still uncertain. Most likely no single factor can be implicated in the etiology; rather, the disease probably results from a combination of influences, including biological, psychological and environmental factors (Townsend, 2002)

## Biological influences

a. **Genetics:** The body of evidence for genetic vulnerability to schizophrenia is growing studies show that relatives of individuals with schizophrenia have a much higher probability of developing the disease than do the general population. Whereas the life time risk for developing schizophrenia is about 1 percent in most population studies, the siblings or offspring of an identified client have a 5 percent to 10 percent risk of developing schizophrenia (Blank & Andreasen, 1994). How schizophrenia is inherited is uncertain. No reliable biological marker has been found (Tsucing & Faraone, 1994)

b. **Twin studies:** The rate of schizophrenia among monozygotic (identical) twins is four times that of dizygotic (fraternal) twins and approximately 50 times that of the general population (Kaplan & Sadock, 1998). Identical twins reared apart have same rate of development of the illness as do those reared together (Townsend, 2002).

c. **Adoption studies:** In Studies conducted by both American and Danish investigators, adopted children born of schizophrenic mothers were compared with adopted whose mother had no psychiatric disorder it was found that the children who were or of schizophrenia mother were more likely to develop the illness than were the comparison control groups (Black & Andresen 1994)

d. **Biochemical influences:** The oldest and most thoroughly explored biological theory in the explanation of schizophrenias attributes a pathogenic role to abnormal brain biochemistry (Birchwood et al; 1989). Notions of a chemical disturbance as an explanation for insanity were suggested by some theorist as early as the mid 19<sup>th</sup> century (Townsend, 2002)

e. **The dopamine hypothesis:** This theory suggests that schizophrenia (or schizophrenia like symptoms) may be caused by an excess of dopamine dependent neuronal activity in the brain (Holpandsworth, 1990). This excess activity may be related to increase production of release of the substance at nerve terminals, increased reports sensitivity, or reduced activity of dopamine antagonists (Birchwood et al; 1989) pharmacological support for this hypothesis exists. Amphetamines, which increase levels of dopamine, induce psychosomatic symptoms (Kaplan & Sadock, 1998). The narcoleptics (e.g chlorpromazine, haloperidol) lower brain levels of dopamine by blocking dopamine receptors, thus reducing the schizophrenic symptoms, including those induced by amphetamine (Abi – Dargham, www.schizophrenicform.org, 12/6/2016).

f. **Other biochemical hypothesis:** various other biochemical's have been implicated in the predisposition to schizophrenia. Abnormalities in the neurotransmitters nor epinephrine, serotonin, acetylcholine and gamma amino butyric acid and in the neuroregulatorys, such as prostaglandins and endorphins, have been suggested cutting (1985), suggests that the body may manufacture a hallucinogen or psychotomimetics that usurps the usual neurotransmitter or neuroregulator pathways in the brains of individuals with schizophrenia

### Physiological influences

a. **Viral infection:** In postmortem studies, Steven (1982) reported observations of degenerative changes within the neurons and an increase in the supporting glial cells of schizophrenic brains. These structural changes are similar to those characteristically reported in infectious inflammatory diseases such as viral encephalitis. Stevens considered these changes in the brains for individuals with schizophrenia to be consistent with a healed inflammatory process

b. **Anatomical Abnormalities:** computed tomographic (CT) scan abnormalities occur in up to 40 percent of schizophrenic patients (Black & Andreasen 1994). Computerized studies with schizophrenic population have suggested that some individuals with the disorder exhibit a reversal of the normal anatomical asymmetry (Birchwood et al; 1989)

c. **Histological changes:** Scheibel and his associates (1990) at the university of California – Los Angeles have studied cerebral changes at the microscopic level. In studying brains of clients with schizophrenia they found a disordering or disarray of the pyramidal cells in the area of the hippocampus

d. **Physical conditions:** Cutting (1986), cites various studies that report a well established, positive link between schizophrenia and the following conditions: epilepsy (particularly temporal lobe), Huntington's chorea, birth trauma, head injury in adulthood, alcohol abuse, cerebral tumor (particularly in the limbic system), cerebrovascular accidents, systemic lupus erythematosus, macadamia parkinsonism, and Wilson's disease

### Psychological influences

a. **Sociocultural factors:** Many studies have been conducted that have attempted to link schizophrenia to social class indeed, epidemiological statistics have shown that greater numbers of individuals from the lower socio – economic classes experience symptom association with schizophrenia than do people from the higher socio – economic groups (Black & Andreasen, 1994). Some studies have attempted to refute this hypothesis and view the link between low

socioeconomic status and schizophrenia as merely a shift downward because of the clients difficulty maintaining stable employment and relationships (Birchwood et al; 1989).

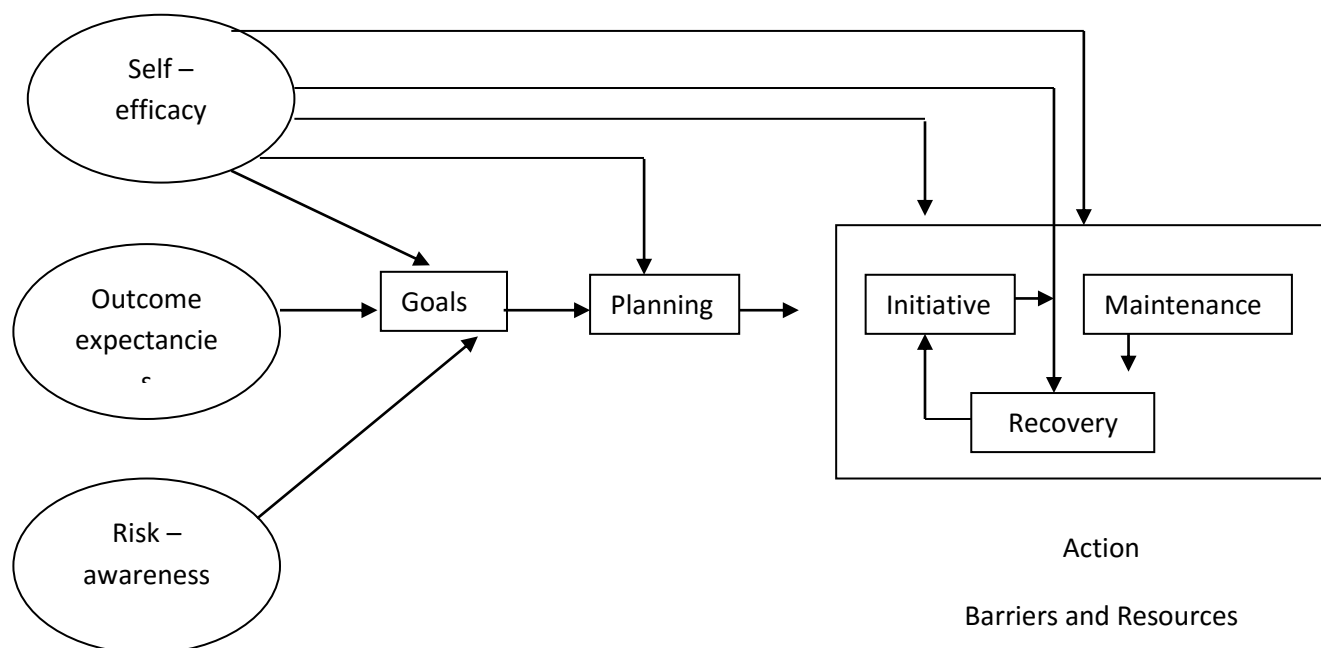
b. **Stressful life events:** Studies have been conducted to help determine whether psychotic episodes may be precipitated by stressful life events. The strongest evidence for the role of stressful life events in schizophrenia comes from the research of Brown and Barley 1968. In the individuals they studied, it was found that stressful events were most likely to have occurred in the 3 weeks period just before the onset of symptoms. Others investigator have supported the hypothesis that stressful life events can precipitate schizophrenic symptoms in a generally predisposed individual (Goldstein, 1987; Lieberman et al; 1984).

**Types of schizophrenia and other psychotic disorders:** The DSM – IV – TR (APA, 2000) identifies various types of schizophrenias and other psychotic disorders as listed below:

Disorganized schizophrenia (previously called hebephrenic schizophrenia; catatonic schizophrenia; paranoid schizophrenia; undifferentiated schizophrenia; residual schizophrenia; schizoaffective disorder; brief psychotic disorder, schizophrenic form disorder, delusional disorder; shared psychotic disorder; psychotic disorder due to a general medical condition and substance – induced psychotic disorder due to a general medical condition and substance induced psychotic disorder

## THEORETICAL THEORY UNDERPINNING THE STUDY

the theoretical adapted for this study is the theory of health action process approach (HAPA). HAPA is designed as a sequence of two continuous self-regulatory processes, a goal setting phase (motivation) and a goal – pursuit phase (volition). The second phase is subdivided into a precaution phase and action phase. Motivational self-efficacy outcome expectancies and risk perceptions are assumed to be predictors of intentions. This is the motivational phase of the model. The predictive effect of motivational self – efficacy on behavior is assumed to be mediated by planning. The latter processes refer to volitional phase of the model



*Fig1: The health Action Process Approach (HAPA)*



Health action process approach (HAPA) is a social – cognition model of health behavior suggesting that health behavior change is a process that consists of a motivational phase and a volitional phase. The motivational phase is the process in which an individual forms an intention to either adopt a precautionary action to change risk behaviors in favour of other. The subsequent volitional phase concerns the processes of implementing intention into actual behaviors, that is, initiation, maintenance and recovery. Ralf Schwazer 1992, 1999, 2001), gives a brief overview of the basic theoretical constructs and assumptions of the HAPA model

**Motivational phase:** The motivational phase is the HAPA is characterized by growing risk awareness, outcome expectancies and perceived task efficacy that lead to the formulation of an intention (fig 1)

**Problem Statement:** Over the years, much debate has surrounded the concept of schizophrenia. Various definitions of the disorder have evolved, and numerous treatment strategies have been proposed, but none have proven to be uniformly effective or sufficient. Although the controversy lingers, two general factors appear to be gaining acceptance among clinicians. The first is that schizophrenia is probably not a homogenous disease entity with a single cause, but rather, it likely results from a variable combination for genetic predisposition, biochemical dysfunction, physiological factors, and psychosocial stress. The second factor is that there is not now and probably never will be a single treatment that cures the disorders. Therefore, this study aimed at determining the efficacy of social skill training and group therapy techniques in managing schizophrenic patients

**Objectives:** The main goal is to determine the efficacy of social skill training and group therapy technique in the management of psychiatric symptoms associated with schizophrenia

### Specific objectives

1. To assess the efficacy of social skill training techniques (SSTT) only in the reduction of symptoms associated with schizophrenia
2. To ascertain the efficacy of group therapy technique in the reduction of symptoms associated with schizophrenia
3. To evaluate the efficacy of both group therapy technique (G) and social skill training technique (SSTT) combined on the reduction of symptoms associated with schizophrenia

**Hypotheses:** Three (3) null hypotheses were set and tested at 0.05 level of significance. They were

1. There is no significant difference in the post – test mean scores in statistical methods of subjects exposed to social skill training technique (SSTT) only. SSTT combined with group therapy, group therapy (GTT) only and the control
2. There is no significant difference in the post mean scores in the statistical methods among subjects exposed to SSTT combined with GTT and GTT only
3. Subjects exposed to the SSTT combined with the GTT and control will not differ in their improvement on the statistical methods

## METHODOLOGY

**Design:** The between subject design of 4 x 4 factorial non – randomized group structured was used in the study. The treatment conditions are represented along the rows while tenure of schizophrenia (Acute and Chronic) are in the columns. The treatment conditions which are

four (4): Social skill training technique (SSTT) only, group therapy Technique (GTT) combined with SSTT, group therapy technique (GTT) only and the control respectively

**Setting:** Four hospitals involved in the management of psychiatric patients were randomly selected from the south – west of Nigeria. They are neuropsychiatric hospital, Aro, Abeokuta Ogun State psychiatric hospital, Yaba, Lagos state Hospital, Akure, Ondo state

The neuropsychiatric hospital, Aro, Abeokuta came into existence in 1954. It was established by decree 42 of 1979 as an affiliate of the university college hospital, Ibadan Aro is a collaborating centre for research and the training in mental health, with the assistance from the World Health Organization (WHO). It is now a recognized national neuron psychiatric hospital. The administration is headed by a provost. It is noted for admission of all sort of patients with mental health challenges psychiatric hospital Yaba is situated in Lagos state and was equally established by decree 42 of 1977. The administration is headed by a chief medical director. It has capacity to admit about 350 patients. It has about 50 psychiatric nurses and many psychiatrist doctors, clinical psychologists social workers, pharmacists and other health work

Psychiatrist, hospital urelu, Benin, Edo State. It is equally a federal government of Nigeria establishments. It has capacity to admit various type of patients with mental health challenge. It was taken over by the Federal government in 1975.

Neuro – psychiatric hospital, Akure is a government owned specialist hospital in Akure South Local government area of Ondo state, Nigeria. It is located at Od Road, Akure. It is headed by chief medical officer who is a psychiatrist with other doctors and nurses

**Subjects:** The patient diagnosed as schizophrenia from the randomly selected psychiatry hospitals in the south – West of Nigeria were the participants in this study between August 2015 and April, 2016. They comprised of four hundred and twenty five (435) patients purposively selected from the four (4) selected hospitals of this number, 73(17.2%) and 86 (20.2%) were taken from neuro – psychiatric hospital, Akure and neuropsychiatric hospital useful, Benin city respectively while 154 (36.2%) and 112 (26.4%) were taken from neuropsychiatric hospitals Aro and Yaba respectively. Two hundred and seventy (270 (63.5%) were males while one hundred and fifty five (155 (36.5%) were females

**Therapeutic procedures:** It lasted for Eight (8) weeks

a. Social skill training techniques (SSTT) it range for eight weeks

**1<sup>st</sup> Week:** Screening of patient. Problem identification is made in collaboration with the patients in the group in terms of the obstacles that are barriers to patient personal goals in his/her current life

**2<sup>nd</sup> Week:** goal setting Generates with patient short term approximation to the patients personal goals with specification of the social behavior that is required for the successful attainment of the short term, incremental goals. The goal setting endeavour requires the therapist or tanner to elicit from the patient detailed description of what type of skills to be learnt, with whom, where and when

**3<sup>rd</sup> Week:** Role plays or behavioral rehearsal, the patient demonstrates the verbal, non – verbal and paralinguistic skill required for successful social interaction in the interpersonal situation set as the goal. Allow patients to ask questions or pose questions to them to determine the level of success. Give home work on corrective measures

**4<sup>th</sup> week:** Positive and corrective feedback after going through the homework's. Positive and corrective feedback is given to the patients focused on the quality of the behaviours exhibited in the role play

**5<sup>th</sup> Week:** Social modeling is provided with the therapist demonstrating the desired interpersonal behaviors in a form the can be vicariously learned by observing patients give home assignment

**6<sup>th</sup> Week:** Positive social reinforcement is given contingent on those behavioral skills that showed improvement

**7<sup>th</sup> Week:** Positive reinforcement and problem solving are provided based on the experience using the skills acquired

**8<sup>th</sup> week:** Post test

### **Group therapy activities**

**1<sup>st</sup> Week:** Icebreakers the members are introduce to each other setting of goals and administration of the pre test

**2<sup>nd</sup> Week:** Treading the group basic of cognitive approach. Asking them information about their behaviors, and their thoughts. Home assignment

**3<sup>rd</sup> week:** behavioral approach focusing attention on self defeating beliefs, relying on group members to identify such beliefs in each other. They patients are accurate to apply behavioral techniques like visualization to help participants think, feel and behave differently

**4<sup>th</sup> week:** use techniques to challenge each group members to examine ineffective attempted solutions. The therapist encourages group members to evaluate and process these attempted solutions and recognize when they are not working, then engage the group in generating alternative solutions give home assignments

**5<sup>th</sup> Week:** Work where appropriate to change group members' perception of problems and help them understand what is happening to them. They therapist should guide the process while group members offer suggestion **6<sup>th</sup> week:** Reinforce the activity of the 5<sup>th</sup> week let them identify and implement effective solution

**7<sup>th</sup> Week:** The therapist should allow the group to direct to examine problems that might result of they do not reframe from the abnormal behavior

**8<sup>th</sup> week:** Administration of post test and clarity and issues troubling the minds of the group member

**Control group:** They are met equally but were only ask on how they were using their drugs. They period the family members had visited

**Note:** Each group interaction did not last more than 45minutes

**Instrumentation:** The only instrument adopted for the study was the social function questionnaire. Hey instrument was modified by Paul Clifford and Isabel Moris. It is divided into 5 sections each contains 8 items to be completed for each person: self care skills, domestic skills community skills, social skills and responsibility. All items are to be completed by the therapists or stall – nurses. The summary sheet enables quick identification of problem areas and also the production of a social function profile. This is produced by summing the items from which rating has been made in each section and dividing that total score by the number of items completed. The psychometric prophetic of the instrument showed inter correlations between the subscales ranged from 0.36 to 0.69.internal consistency coefficient for the subscales ranged from 0.80 to 0.89 and test – retest correlations ranged from 0.80 to 0.090 (Konrand, Joanna Stanislaw, 2005)

**Sample size and sampling technique:** Out of all psychiatric hospital in Nigeria four (4) psychiatric hospitals were randomly selected through secrete balloting system all the hospital both federal government and state government psychiatric hospitals were given numbers. The numbers were written on a small sheet of paper and put in a bowl. The researchers have decided to select four before proceeding on the random selection. The first ballot paper was selected and consequently three others were selected after each of the selection, the container would be sieved before the picking of the ballot paper. However, the participants were purposively distributed into SSST only, GTT only, SSST combined with GTT and control groups

**Inclusion criteria:** All patients diagnosed as having schizophrenia and have commenced medication in the last one week, either bring admitted for the first time (acute) or being re – admitted (chronic). Should be 25years of age and above

**Exclusion criteria:** All patients that would not have stayed for one week, seriously violent and with age below 25 years of age

**Results :** Results are presented in tabular form forms labeled as tables 1

**Table1:***Demographic characteristics of respondents*

Sex		
Male	270	63.5%
Female	155	36.5%
Total	425	100%
Married		
Married	200	47.1%
Unmarried	210	49.4%
Widow	02	0.5%
Unclassified	13	03.1%
Total	425	100%
Age		
25 – 30	103	24%
31 – 36	174	40.9%
37 – 42	98	23.1%
43 – 48	40	09.4%
49 – 54	10	02.4%
Total	425	100%

Religion		
Christians	200	47.1%
Muslims	210	49.4%
Not specify	15	03.5%
Total	425	100%

Table 1 showed two hundred and seventy (270) (63.5%) were males while one hundred and fifty five (155; 36.5%) were females. The marital status of the subjects also varied as two hundred and ten (210 ; 49.4%) were unmarried, 200 (47.1) were married while 02 (0.5%) and 1.3 (3.1%) represented the widows and those who did not specify their marital status. Their age categorization of the subjects were 25 – 30 = 103 (24%), 31 – 36 = 174 (40.9%); 37 – 42 = 98 (23.1%) 43 – 48 = 40 (9.4%) and those in the age group of 49 – 54 = 10 (2.4%) respectively. In terms of the religious affiliation, Christians accounted for 200 (47.1%), Muslims 210 (49.4%) while 15 (3.5) did not specify their religion.

**Table 2:** Posttreatment comprise of SSTT, SSTT + GTT, GTT and control using multi – group ANOVA

Source of variation	Df	Ss	Ms	f-ratio OBS	F ratio	P
Between group	7	53116.9	7588.1	78.96	2.02	xx
Within group	417	49968.32	96.09			
Total	424	93185.22	7684.19			

Xx significant at 0.05

The result on the table 2 showed that there was no statistical significant the findings showed that  $df\ 7/417 = 78.96, p > 0.05$

**Table 3:** Rows and column of adjusted means

Rows	Chronic schizophrenia	acute schizophrenia
Social skill training techniques	50.38	48.32
Social skill training + group therapy	61.46	58.98
Group therapy technique	43.01	40.672
Control	28.63	29.71

As indicated in table 3, the post mean scores of the respective groups showed that the group that had the combination of SSTT and GTT demonstrated the highest mean scores advantage. Those treated with SSTT only, GTT only and control also went in that order, however control group showed low mean scores when compared to the other groups in terms of improvement. They schizophrenia patients with chronicity improved better than the patients with acute schizophrenia.

**Table 4:** post treatment compares' on fSSTT / GTT and GTT only using multigroup ANOVA

Source of Variation	DF	SS	MS	F Ratio OBS	F Ratio CRIT	P
Between group	3	3684.9	1228.3	30.5	2.62	xx
Within group	392	15786.1	40.27			
Total	395	19471.0	1268.57			

xx significant at 0.05

Table 4 above, showed that there was no statistical significance when the SSTT + GTT were compared with GTT only. They findings shred that  $df = 3/395 = 30.05$  ( $p > 0.05$ )

Table 5: *Post treatment comparison of SSTT + GTT and control using multi group ANOVA*

Source of Variation	DF	SS	MS	F Ration OBS	F Ration CRIT	P
Between group	3	2133.14	711.05			
Within group	194	3360.08	17.32	41.04	2.65	xx
Total	197	5493.22	728.37			

xxsignificant at 0.05

## DISCUSSION

As noted in the findings emanating from the computed data, the group therapy alone could not be said to be realistic in treating the psychopathology associated with schizophrenia, this finding supported the finding of Keith and Mathews (1984) when they said that the group therapy should not be used at the on-set of schizophrenia, however, the finding was at variance with Kaplan and Sadock (1998) when they said group therapy has a place in the management of schizophrenia. However, it was observed the combination of SSTT and GTT showed an improvement statically which means, it would be better to use eclectic approach in the use of psychosocial management of patients with schizophrenia. This was reflected in table 3. this finding was congruent with Townsend, 2002, Solomon & Drane 1995 Kaplan and Sedok, 1985; Stanley and Schwetha, 2006, Penn & Mueser, 1996, Table 3, wet further to show to show that the patients with chronic schizophrenia improved better than the patient with acute schizophrenia. This finding corroborated the finding of cutting 1985 which stated that group therapy in the management of schizophrenia has reported meager but positive report. In the same vein, Bellack, (1984) opined that the nature of patients should be considered when trying to use social skill training

## CONCLUSION

Considering the outcomes of this study, it was concluded that no single psychological managements could be used to reduce psychopathological problems associated with schizophrenia. In the process of using psychopharmacology therapy, it is imperative to introduce psycho therapeutic therapy in order to get a good result

## IMPLICATION FOR NURSING PRACTICE

As soon as the diagnosis of schizophrenia is made, psychiatric nurses should put into practice the use of psychotherapy to run simultaneously with pharmacology therapy. Nurse should realize that only one therapy may not produce the expected results therefore they should be involved in the use of eclectic approach

## RECOMMENDATION FOR FURTHER STUDY

It is recommended that the study should be conducted to cover all mental disorder.

**Conflict of interest:** no conflict of interest

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